DOCUMENT RESUME

ED 406 637 CG 027 756

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TITLE Collaborating with Teachers, Parents, and Others To Help Youth at Risk.
PUB DATE 9 Aug 96
NOTE 39p.; Paper presented at the Annual Meeting of the American Psychological Association (104th, Toronto, Ontario, Canada, August 9-13, 1996).
PUB TYPE Information Analyses (070) -- Speeches/Meeting Papers (150)
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Adolescents; At Risk Persons; Children; Elementary Secondary Education; *High Risk Students; *Integrated Services; Parent School Relationship; Partnerships In Education; *Pupil Personnel Services; School Community Programs; *School Counseling; *School Psychologists
IDENTIFIERS School Based Enterprises; *School Based Services

ABSTRACT

During the 1990s, school-based and community-based collaboration efforts to improve the quality of the overall human services delivery system for at-risk children, youth, and their families has grown substantially. The greater responsibilities of psychologists in formulating, implementing, and evaluating school-linked and school-based collaborative models are discussed here. Three major objectives are outlined: (1) to provide school psychologists with a concise overview of contemporary programs and practices which are designed to develop and implement effective collaborative models involving school personnel, youth, families, and community agencies; (2) to identify and to discuss specific substantial obstacles to effective collaboration among school personnel, parents, and representatives of community agencies who work towards more positive student outcomes; and (3) to identify and to discuss specific strategies whereby school psychologists can overcome common obstacles to effective collaboration and can participate more effectively in efforts to promote well-being for all youth and their families. Contains 59 references. (RJM)

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ED 406 637

COLLABORATING WITH TEACHERS, PARENTS, AND OTHERS TO HELP YOUTH AT RISK

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Paper Presented at the 104th Annual Convention of the American Psychological Association, Toronto, Canada
August 9, 1996

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ABSTRACT

During the 1990s, school-based and community-based collaboration efforts to improve the quality of the overall human services delivery system for children, youth, and their families who are considered to be at risk have grown substantially. Increasingly, school psychologists are being asked to play a more prominent role and to assume greater responsibilities in the formulation, implementation, and evaluation of school-linked and school-based collaborative models which are designed to provide more comprehensive and integrated mental health services to students and their families.

This paper has three major objectives: (1) to provide school psychologists with a concise overview of contemporary programs and practices which are designed to develop and to implement effective collaborative models involving school personnel, youth, families, and community agencies (e.g., school-based, school-linked, and full-service school models); (2) to identify and to discuss specific factors and conditions which often serve as substantial obstacles to effective collaboration among school personnel, parents, and representatives of community agencies in their efforts to produce more positive student outcomes (e.g., confidentiality barriers, governance issues, inadequate program evaluation, and a wide variety of professional "turf issues"); and (3) to identify and to discuss specific strategies whereby school psychologists can overcome common obstacles to effective collaboration and to participate more effectively in collaborative efforts to promote more positive outcomes, particularly those involving prosocial, emotional, and behavioral well-being, for all youth and their families.

COLLABORATING WITH TEACHERS, PARENTS, AND OTHERS TO HELP YOUTH AT RISK

Introduction

The 1990s have witnessed a rapidly growing movement throughout the United States to develop more effective collaboration among education and all major human services agencies which serve children, youth, and families considered to be at risk. The current overall human services delivery system has been widely criticized as being largely ineffective and inefficient to meet the comprehensive, and often, complex needs of increasing numbers of children and their families who find themselves in at risk situations (Dryfoos, 1994; Kagan, 1991; Levy & Shepardson, 1992; Melaville, Blank, & Asayesh, 1993; Morrill, 1992; Weissbourd, 1996).

Many educational and social reformers presently are calling for a major restructuring of our schools to allow for the delivery of mental health, health, and social services to students in their families which are more comprehensive, intensive, less fragmented, more easily accessible, and more culturally sensitive (Davis, 1994 a, b; Dryfoos, 1994; Howe, 1993; Kirst, 1993; National Commission on Children, 1991; Schorr, 1989; Weissbourd, 1991, 1996). Several communities already have implemented comprehensive service delivery models which involve school-based or school-linked integration components such as the Caring Communities Project in St. Louis, the New Beginnings Project in San Diego, the New Futures Projects which are operating in several states, and the Olympia Schools Project in Olympia, Washington (Center for the Future of Children, 1992).

Proposals to link health services, social services, and mental health services to schools increasingly are at the forefront of our nation's policy agenda involving children and their families (Davis, 1994a, 1994b; Davis,

1995a, Davis, 1995b; Gardner, 1992; Dryfoos, 1994; Schorr, 1989; Weissbourd, 1991, 1996). In recent years, numerous conferences and symposia also have focused on the issue of developing and implementing more effective collaborative programs among educators and other human services providers to more effectively connect and integrate needed services for at risk youth and their families. Likewise, the professional literature has reflected an unprecedented growth of material focusing on this issue. Collaboration clearly has become the buzzword of the mid-1990s.

Arguments for more effective collaboration among schools and agencies to more adequately meet the needs of children and their families are compelling. Our nation's current system of care for vulnerable children and their families, organized narrowly to respond to categorically-defined problems, has been widely criticized as not being able to respond effectively to the comprehensive needs and circumstances of many of its clients. Children and families who need assistance often must go to multiple locations and frequently endure duplicative assessments to order to receive what are often fragmented and insufficient services (Schorr, 1989; Weissbourd, 1991, 1996). Also, as suggested by Weissbourd (1996) the current system largely is driven by bureaucratic and funding mandates and not by the real needs of children and families, whose problems often are treated in isolation from each other as well as through the individual lens of each individual discipline involved.

While the inconsistencies and inadequacies of our current human service delivery system have long been recognized, pleas for change have become substantially more widespread and intense as the result of several recent reports and studies highlighting the rapid deterioration in the health, social, and educational well-being of our nation's children and youth and their

families (Carnegie Corporation of New York, 1994; Center for the Study of Social Policy, 1993; Children's Defense Fund, 1994; Hodgkinson, 1992, 1993; National Commission on Children, 1991).

Recent and current educational reform efforts taking place within our nation's public schools also has served to focus interest on the need to develop and implement more effective collaboration models for children and families. Frequently criticized as not successfully meeting the "educational needs" of students as well as not meeting society's need to develop an educated and skilled workforce, school personnel in many states and in many local communities increasingly are seeking help from other sources, especially from other agencies who traditionally are involved with youth at risk.

Public school teachers and administrators often argue that the personal and social problems of many of today's students -- problems which they bring with them to school each day -- serve as major impediments not only to their ability to instruct these students but also serve to prevent many students from learning. Realizing that they alone cannot, and should not, be expected to "fix" these problems, educators increasingly are looking for help.

Current Status of School-Linked and School-Based Programs

Initiatives to restructure community human services and community health services have provided impetus for the current school-linked services movement throughout the United States, and they have led to the widespread development of school-based and school-linked health clinics. It is estimated that there are nearly 700 school-based health centers (SBHCs) currently in operation in our nation's schools. As psychosocial problems reportedly are either the most or second most frequent reason for referral at SBHCs, SBHC

staff presently are calling for personnel and programs to specifically address the mental health needs of the students which they are serving (Weist, 1996).

Current use of the terms school-based and school-linked tends to encompass two separate dimensions: (1) where programs/services are located and (2) who owns them. As the term denotes, school-based indicates activity carried out on a school site; school-linked refers to off-school site activity with formal connections to a school site. In either case, programs/services may be owned by schools or a community-based organization, or in some cases, they are co-owned. In addition, the term school-linked tends to be associated with the notion of coordinated services and school-community collaborations (School Mental Health Project/Center for Mental Health in Schools Newsletter, 1996).

In addition, several communities are in the process of developing full-service schools which rely heavily upon effective collaboration among key human services agencies (e.g., the IS 218 model in the Washington Heights section of New York City; the Hanshaw Middle School model in Modesto, California; the Pinellas County Public Schools model in Florida (Davis, 1995a, 1995b; Dryfoos, 1994, 1995; U.S. Department of Education & American Educational Research Association, 1995).

Despite the growing popularity of school-linked and school-based programs throughout our nation, proponents of these programs currently are raising several cautions, issues, and concerns which they suggest are severely impeding their optimal development and implementation. Dryfoos (1995) argues that most school-linked and school-based collaboration programs which have been developed thus far have failed to result in any substantial changes in the overall governance structure of those schools and those agencies involved. For example, outside agencies such as community mental

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health centers typically have not been involved in school restructuring efforts, nor have school systems been involved in the governance of the provider community mental health centers. Thus, despite relocating some services and generally improving access to those services, rarely have new organizational entities been formed. In order to develop truly comprehensive and integrated programs to youth and families over time, advocates argue that fundamental changes must occur relative to the overall governance of the entire process. Evidence of such thus far has been lacking.

In a similar vein, Adelman and Taylor (1993) suggest that most current efforts to develop integrated, comprehensive school-linked and school-based programs, especially those related to student mental health issues, have not produced the positive outcomes which had been anticipated because they (1) lack an overall plan to ensure continuity; (2) are too piecemeal in development and implementation; (3) fail to adequately utilize the wide array of resources which already exist in many schools; (4) fail to sufficiently involve mental health professionals in overall program development and coordination aspects (excessive direct service expectations); (5) typically are too narrowly focused (primarily addressing the needs of those special education populations with the perceived "greatest needs" without sufficient attention being paid to a school district's broader population of students; and (6) devote inadequate attention to prevention and early intervention programs for children, youth, and families.

Thus, given the conditions and situations discussed above, one might speculate that we would be witnessing far more widespread evidence of effective collaboration among schools and other agencies than presently exists throughout the nation. Clearly, several "success stories" have been

documented in this regard. Yet, given the widespread dissatisfaction with the current system, along with the seemingly solid arguments which have been offered on behalf of increased agency collaboration as an effective vehicle for solving the complex problems of children and families in today's society, one might reasonably ask why we are not experiencing substantially more "successes."

Despite what often appear to be well-intentioned efforts to implement effective and efficient collaborative, comprehensive programs to better serve children and their families, these efforts often fail to produce the expected positive outcomes. It is suggested that "collaboration failures" often are the result of several factors, conditions, and behaviors which frequently serve as major obstacles to the overall collaboration process. Some of these suggested obstacles are primarily concerned with more formal policy, bureaucratic, legislative, professional, and legal issues. Other obstacles, however, tend to be of a much more informal nature, typically having their roots in the peer interpersonal relationship domain, and these are the specific obstacles which often constitute the most substantive and the most difficult to overcome.

Obstacles

The following six obstacles or cautions should be considered by school psychologists and others seeking to develop and implement effective interagency collaboration models as they frequently hold the potential to seriously erode the overall process.

Failure To Recognize Common Myths and Misconceptions About "At Risk"

Several misconceptions involving students at risk exist which, individually and collectively, frequently serve to impede effective collaboration. Among the most common of these misconceptions are the

following: (1) we cannot accurately define the term at risk -- therefore, we are unable to identify which children and youth would benefit from collaborative services; (2) the problems of children and youth considered to be at risk are isolated from those of their families; (3) we lack sufficient knowledge relative to which policies, programs, and practices work most effectively for children and families in at risk situations.

Inadequate Understanding of the Collaboration Process

Well-intentioned collaboration efforts often fail because participants lack a real understanding of the collaboration process per se. They fail to recognize that effective collaboration is a complex process which requires a common vision; careful planning; the establishment of realistic goals; a willingness to make decisions which often are difficult and which usually involve professional tradeoffs and sacrifices; sufficient time; and most of all -- a great deal of hard work.

Conflicting Views: Roles and Responsibilities of Schools

Not everyone agrees that schools should become involved in the provision of health and social service programs for students. A commonly heard criticism of U.S. public schools in the mid-1990s is that they have strayed from their primary mission: improving student learning and student academic achievement, and that their involvement in such activities as the offering of sex education classes, the establishment of on-site student health clinics, and/or the offering of parenting classes and daycare services only serves to further erode this "academic mission" (Committee for Economic Development, 1994). Clearly, conflicting views regarding the specific roles and responsibilities of public schools exist not only among professionals, but also

among parents and citizens in most communities. In particular, members of the New Religious Right have been especially vocal in their criticism of public schools in this regard (Davis, 1996). Interagency collaboration efforts often are thwarted because insufficient attention is devoted to this situation.

Failure To Acknowledge Cost

Frequently interagency collaboration is viewed primarily as a cost-savings effort. The idea of integrating programs and resources from several independent agencies and consolidating them into one generic program holds a great deal of appeal for persons interested in saving money. While excessive duplication of services -- and related costs -- often can be substantially reduced through well-designed and effectively-administered interagency collaboration efforts, these efforts frequently fail because insufficient fiscal resources are allocated to produce the anticipated positive outcomes.

Professional Turf and Confidentiality Issues

One of the most substantial obstacles to effective collaboration continues to involve professional turf issues, concerns, and dynamics. Effective collaboration often is impeded because participants who are attempting to engage in this process typically experience personal and professional anxieties and frustrations involving their respective roles and responsibilities. At times, awkward dilemmas are created as a result of individuals trying to "protect their turf and their disciplines." Frequently, vital information about children and families which is critical to the success of the overall collaboration process is not shared among participants with the

reason most frequently offered for the absence of this sharing: confidentiality restrictions.

Lack of Adequate Evaluation Model

Despite the many promises that collaborative programs are suggested to have for producing positive outcomes for children, youth, and their families at risk, the bottom-line question, quite appropriately, is do these programs really work? Do school-based health clinics, for example, reduce teenage pregnancy rates and curtail the spread of sexually transmitted diseases among youth?

Are full-service schools, which are open longer periods during the typical school day and, in some cases, on weekends, any more effective in increasing family involvement and/or in reducing negative student behavioral patterns than are more traditional school models? Unfortunately, many interagency collaboration efforts are destined to fail from the very outset because insufficient attention was given to the development and implementation of an effective evaluation model. Very simply, a lack of adequate empirical data relative to measuring anticipated specific project outcomes often results in potentially valuable programs being eliminated.

Strategies for Overcoming Obstacles

The following seven specific strategies are offered to assist school psychologists and other planners overcome many of the commonly recognized obstacles to effective collaboration among educators and human services agency personnel in their efforts to produce more positive outcomes for children and their families who are considered to be in at risk situations.

Confront Common Myths and Misconceptions

Myth 1: We cannot accurately define "at risk".

This commonly expressed viewpoint often serves no other purpose than to delay the delivery of needed services to vulnerable children, youth, and their families. Clearly, confusion exists regarding the specific definition of at-risk. Various disciplines (e.g., mental health, education, health, juvenile justice, and health) generally view the term at risk quite differently and typically from a very narrow perspective. Within the education field per se, students at risk generally have been regarded as those youth who are likely either to drop out of school or to graduate without the necessary skills to succeed academically, socially, and/or vocationally in society (Davis, 1993a, 1993b; Davis, 1995b; Davis & McCaul, 1990; Slavin, 1989).

Some observers have taken issue with the term student at risk. For example, Herb Kohl (cited in Nathan, 1991) stated: "I have never taught an 'at-risk' student in my life. The term is racist. It defines a child as pathological, based on what he or she might do rather than on anything he 'or she has actually done. It is a projection of fears of educators who have failed to educate poor children" (p. 679).

In particular, most advocates of the resilience research paradigm, which recently has witnessed a great deal of attention and support from professionals working within the education, health, and child protective fields, have raised strong objections to the at risk label being applied to children and families. The resilience researchers (e.g., Burns, 1994; Fine, 1995; Lubeck, 1995; Swadener, 1995) argue, accurately in my judgment, that far too much emphasis traditionally has been placed on the identification of factors and conditions which are assumed to be deficits in individuals or groups of individuals (a practice which often leads to both harmful labeling and lowered

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expectations) rather than focusing more appropriately on the strengths and the protective factors which these individuals and groups frequently possess.

Other skeptics frequently argue that the term at-risk is too broad to precisely define, suggesting that all children and youth could be considered to be at risk in one or more ways. Clearly, in recent years, this term, because of its broad-based and diverse usage, may have lost some of its meaning and impact. Nevertheless, it should be patently evident to anyone who has had regular contact with children and schools in today's society that some children are at far greater risk than are others (Davis, 1995b, 1995c).

Risk is a matter of degree. For some students only relatively mild problems must be overcome. Other students are extremely resilient, and they are able to overcome what are often horrific conditions and circumstances (e.g., extreme poverty, family dysfunction, inadequate healthcare and housing, abuse). Nevertheless, there is widespread support for the position that large and rapidly growing numbers of children and youth in today's society are in severe trouble and that they require both immediate and long-term interventions (Carnegie Corporation of New York, 1994; Chafel, 1993; Children's Defense Fund, 1994; Davis, 1995b).

For educators simply to label a group of students as at-risk is of little or no instructional value. Further, this practice can produce negative consequences for students in several ways (e.g., receiving an overall curriculum which is unchallenging; contributing to feelings of low self-worth; instructional and social isolation from peers etc.). At the same time, however, it is important that we do not ignore the real needs that many of today's students possess, and in the process, deny them the interventions that they require to succeed both in school and in life (Davis, 1995a, 1995c).

Myth 2: The problems of children and youth at risk can be isolated from those of their families.

Many intervention programs for children and youth at risk are ineffective because they fail to recognize that most often the problems of at-risk children and youth are closely interconnected with those of their families, and further that the problems of children and their families are interrelated with those of their communities (Hodgkinson, 1992; Melaville & Blank, 1991; Melaville, Blank, & Asayesh, 1993; Schorr, 1989; Weissbourd, 1996).

Collaboration efforts, in order to be fully effective, must focus on the family and the community. The efficacy of most school-based intervention programs for youths considered to be at risk, for example, is largely determined by the extent to which these interventions include close, meaningful family and community involvement.

Children and youth, in most situations, cannot be effectively helped in isolation. At times, it may even be necessary to provide help first to the family of a child or youth prior to implementing interventions for the child/youth himself or herself. Clearly a school's responsibility lies first and foremost with the individual student and his or her needs. However, results of recent studies related to interagency collaboration efforts strongly suggest that that those programs which hold the highest likelihood for success are those which include the student's family and community in an active, integrated, and meaningful manner. These programs tend to allow for much easier access, and they are far less likely to result in the delivery of fragmented or unnecessarily duplicative services. (Davis, 1993a; Davis, 1993b; Davis, 1995c; Dryfoos, 1994; Morrill, 1992; Schorr, 1989; U.S. Department of Education & American Educational Research Association, 1995; Weissbourd, 1996).

Myth 3: We lack sufficient knowledge regarding what works.

It is simply not true that we lack a sufficient knowledge base about which programs and practices are most effective in producing positive outcomes for children and families considered to be at risk. This misconception frequently represents a major obstacle to the implementation of potentially successful pr grams for these children and youth.

We know what works. A large body of empirical research involving "students at risk," for example, has provided us with a reasonably rich knowledge base. As a result of these studies, we know that successful academic programs typically contain several key elements. They are comprehensive, intensive, continuous, and provide immediate feedback. Successful programs are those which are flexible and adaptable to individual student needs. Also, these programs emphasize one-to-one and small group interventions, provide for the measurement of objective and meaningful outcomes, and are sensitive to the cultural, racial, and gender needs of participants (Schorr, 1989; Slavin, Madden, Dolan, Wasik, Ross, & Smith, 1994).

In the broader perspective, we have ample, documented evidence, for example, that quality early childhood intervention programs promote positive growth in many domains (e.g., health, cognitive, language, social/emotional) for "disadvantaged" children. We know that Head Start works, but many "eligible" children continue to be denied participation in this program because of fiscal restrictions. We know that early and frequent prenatal care can significantly reduce the risk of low birthweight babies (Carnegie Corporation of New York, 1994; National Commission on Children, 1991).

We know also that pregnant teenagers who are encouraged (allowed) to stay in school have a much better chance of completing their education and that they are far less likely to drop out. We also know that quality child care

programs and parenting classes held in schools allow many teenage women to complete their education (Children's Defense Fund, 1994, 1995; Davis, 1995c; Davis & McCaul, 1991).

Finally, we know that early health care, including necessary immunizations, along with proper nutrition, can prevent the occurrence of serious or even fatal diseases in children. Lack of knowledge is not the real issue. The real issue has been, and continues to be, our nation's lack of willingness to demonstrate the necessary commitment to procure the necessary fiscal and human resources to solve the problem (Schorr, 1989).

Too often effective collaboration among potential service providers is unnecessarily impeded because myths and misconceptions involving children and families at risk have not been directly confronted. Valuable time is wasted by engaging in discussions involving issues which have already been resolved -- or should have been -- based upon convincing findings obtained through earlier research. At the very outset of the collaboration planning process, it is important that commonly cited myths and misconceptions be directly confronted.

Develop a Clear Understanding of the Collaboration Process

Implementation of effective interagency collaboration models requires a high level of commitment to the collaboration process per se. This process generally is complex, and it often is extremely difficult to accomplish. Efforts to develop and implement effective collaborative programs often "fail" because the participants who are attempting to create effective, interagency collaboration models lack a solid understanding of this process. Due to this basic lack of understanding, mistakes frequently are made at the very

initiation of the process which serve to ensure that this process will be destined for ultimate failure.

Collaboration among school psychologists, educators and other human services providers represents far more than simply talking about common problems. Also it involves a great deal more than merely learning about each others' services or even the coordination of the delivery of services to children and families. While effective communication and coordination are essential as building blocks in the overall collaboration process, true collaboration represents substantially more in terms of commitment, time and effort (Davis, 1993b; Melaville, Blank, & Assayesh, 1993).

The collaboration process involves a shared common vision and the willingness of those involved to make some difficult sacrifices and tradeoffs. It involves the need for strong consensus-building and typically demands the willingness of all participants to accept new governance and funding structures. Issues such as professional turf, credentialing, and control must be acknowledged and resolved to the reasonable degree of satisfaction of all involved. Student/client and family confidentiality issues and concerns must be addressed. Effective interagency collaboration, even under the best of circumstances, takes time and hard work (Melaville, Blank, & Asayesh, 1993).

In brief, school psychologists, educators and other human service providers must recognize, from the very beginning, that collaboration is a very difficult, demanding, and time-consuming process. It important that those involved in this process fully understand the difficulty in creating new institutions and in convincing entrenched bureaucrats to change their ways and share authority and decision making process (Dryfoos, 1994).

School psychologists and other program developers must guard against viewing collaboration as an end but rather as a means for accomplishing

desired positive outcomes for children and families -- and they must be careful not to raise unrealistic expectations relative to the eventual success of their collaboration efforts. Finally, participants engaging in this process must be aware that they are likely, from time to time, to experience feelings of varying degrees of anxiety and frustration. These feelings generally are entirely normal, and they probably occur as a result of the behavior which participants in the collaboration process typically are unaccustomed to experiencing -- succinctly described by Dryfoos (1994) as "an unnatural act between nonconsenting adults" (p. 149).

Acknowledge and Directly Address Conflicting Views Involving the Roles and Responsibilities of Schools

Despite the many strong arguments in support of school-linked services and development of collaborative programs among schools and human services agencies, including the establishment of full-service schools, it is clearly evident that many citizens, including many educators, are opposed to programs which involve an increase in the numbers and types of health, mental health, and social services within public schools. While the reasons for opposition to the increased involvement of these programs and services are multiple and complex, they typically represent two basic themes.

First, the public school system frequently is criticized for having lost its sense of priorities and having strayed from its primary mission: improving student learning and academic achievement (Committee for Economic Development, 1994, p.1). Some critics claim that "our schools are not social service institutions, and they should not be expected to deliver or pay for health or social services for students" (Committee for Economic Development, 1994, p 1). Therefore, as public criticism increases relative to the perceived

inferior academic performance of American students, the suggestion that our schools become actively involved in the delivery of health, mental health, and social service programs is viewed by some as inappropriate and likely counter-productive to education's primary, if not exclusive, mission (Davis, 1994c).

Opponents of school-linked services and full-service schools argue that our public schools already have demonstrated that they cannot adequately meet their primary mission: to prepare students academically. To ask them to "take on other roles and responsibilities" will only serve to erode even further what has already become an inefficient and ineffective system (Bennett, 1988; Buehrer, 1995; Finn, 1991).

Second, the school-linked services and the full-service schools movement increasingly is being targeted for intensive criticism by the members of the "New Religious Right" (Davis, 1996).

In the eyes of the vast majority of the leaders and followers of the "New Religious Right", school-linked human services programs and full-service schools are viewed as promoting secular humanism and are depicted as contributing to the demise of society (Schlafly, 1991; Simonds, 1993). In particular, objections are raised to the establishment of student health clinics in schools, sex education and sexuality curricula, and outcome-based education. Almost any form of mental health counseling provided to students is regarded as "inappropriate" or even "evil." Likewise, the establishment of day care facilities in schools for the babies of young women students to encourage them to graduate typically is unacceptable to members of the Christian Right, because it promotes immoral and irresponsible behavior (Davis, 1995d; Davis, 1996).

Proponents of collaborative school-linked or school-based programs believe these arguments represent a narrow vision of education and teaching and a denial of the harsh realities faced daily by large and growing numbers of youth and their families in contemporary American society. Urging schools to limit their mission to cognitive and academic achievement domains is "based on the erroneous assumption that children and youth can (or should) block out everything that may be interfering with their ability to focus on academics during the typical school day".

School-linked human services programs, especially those which attempt to establish full-service schools require a new concept of schooling -- one that, if it is to be truly responsive to the multiple and complex needs of youth at risk and their families, must embrace a broader vision and mission for public education. Proponents of these programs need to be acutely aware of dissenting viewpoints involving the roles and responsibilities of public schools in the mid 1990s and be prepared to address these issues very early on in the overall collaboration process. Likely criticisms and potential objections need to be anticipated and a concerted effort made to address them in as open and constructive manner as possible. Many potentially effective collaboration efforts never materialize because insufficient attention is devoted to attempting to deal with these issues up-front.

It is critical that broad-based community input be obtained very early in the collaboration process not only to provide a clear explanation of the rationale for the project and to solicit support for its goals, but also to reduce the likelihood of its failure because of misunderstandings, perceived lack of opportunity for input, or the spreading of inaccurate information by

particular individuals and groups during latter stages of the collaboration process.

The failure to obtain sufficient broad-based community involvement during the very early stages of collaboration efforts to implement several currently operating school-based and school-linked programs has been specifically cited as one of the most substantial reasons why these programs have not been able to produce the level of expected positive outcomes for youth and their families which had been anticipated (Dryfoos, 1995; School Mental Health Project Newsletter, 1996; White and Wehlage, 1995).

Acknowledge the Costs Involved in Effective Collaboration

Most comprehensive interagency collaboration efforts generally should not be viewed as saving large sums of money -- at least not in the short-term. In fact, many of these programs are likely to require an increase in initial funding. However, by placing emphasis on prevention-type activities and by concentrating efforts on helping children and families deal with problems before they escalate into more serious - and usually -- more expensive problems, it is entirely reasonable to project long-term cost-savings.

Program planners who attempt to "sell" the benefits of the establishment of an interagency collaboration model based primarily on anticipated "cost savings" are likely to encounter difficulties. First, they should anticipate the likelihood of having to experience eventual charges relative to their own credibility. Second, should they truly believe that their model is likely to result in substantial cost savings in the short-term, not only are they likely to be sorely disappointed but also, and more importantly, their efforts predictably will not result in anticipated positive outcomes for their clients.

Effective interagency collaboration models which are designed to deal with multiple and complex problems faced by children and families considered to be at risk in today's society are not inexpensive to develop and implement. This point needs to be clearly acknowledged and made.

Dryfoos (1994) estimates, for example, that it costs at least $100,000 a year to initiate even a modest school-based health and social services program, not including the in-kind contributions of both the schools and community agencies. Obviously, the overall cost can be much higher depending on the size of the school and the comprehensiveness of the program.

Dryfoos (1994) further cautions that all programs will require new funds, at least for initial staffing, starting with a full-time coordinator. The creation of new programs which are entirely dependent on "reconfigured funds" (moving existing funding from one program or agency to another) has not as yet been demonstrated in any place identified to date.

Creative financing strategies among all agencies at the federal, state, and local levels involved with youth at risk and their families will need to be developed if full-service schools to be implemented effectively. Current funding streams which typically are very categorical and restrictive will need to be reassessed, and, if necessary, revised to become more responsive to the real needs of disadvantaged children and families. The bottom-line, however, is that effective and responsive full-service schools are not cheap (Davis, 1995c).

We know that youth who drop out of school are much more likely to "cost society more" than those youth who successfully complete school (Hodgkinson, 1992; 1993; National Center for Educational Statistics, 1994; U.S. Department of Education, 1993). We also have compelling evidence that supports the advantages of almost all early intervention programs over

remedial programs for youth at risk and families (Children's Defense Fund, 1994; Hodgkinson, 1992, 1993; Schorr, 1989). The very essence of the full-service schools concept involves integrated, comprehensive, prevention-type interventions. Although we live in a society which usually is looking for "quick fixes" and simple solutions, advocates of full-service schools must be prepared to argue for the long-term cost benefits which these schools are expected to provide (Davis, 1995a).

Acknowledge and Deal with Professional Turf and Confidentiality Issues

Collaboration requires basic understandings of several professional disciplines. Each discipline usually has its own rules, regulations, and professional jargon. Frequently, the collaboration process fails to produce anticipated positive outcomes because the participants become excessively engaged in attempting to defend their own professional turf. Essentially, turf usually involve struggles over power and control.

Debates often occur relative to the issue of "who" (which discipline) presumably is the one who is in the best position to help a particular child or family. Individuals from different disciplines typically view the "problem" from the perspective of their own discipline. Often they view their own discipline as the only one which is truly capable of helping solve the problem. Unfortunately, most professionals have had little, if any, cross-discipline training. They are accustomed to viewing solutions to problems facing children and families through the narrow lens of their own particular formal training and job experiences.

It is necessary for participants in the interagency collaboration process to be willing to question many of the basic assumptions underlying their profession's "narrow" approach to solving problems. Often, what is required is

that participants engage in serious efforts to question some long-held and very cherished belief systems involving what "works best" for vulnerable children and families. They must be willing to discuss alternative paradigms and intervention approaches which are based upon professional belief systems which, at times, may be very different from those to which they have been accustomed (Davis, 1994d).

Program planners involved in the collaboration process continually are being requested to make sacrifices and tradeoffs involving issues and questions related to their past and current professional training and experiential base. Usually, these tradeoffs and sacrifices are difficult, and generally they require substantial courage and trust. Yet, absent the willingness to maintain a broad view or to make the necessary sacrifices, collaboration efforts seldom result in positive outcomes for children and families.

A central goal of service integration programs is to coordinate the efforts of several agencies that are working with the same child and/or family. In most instances, this effort requires the sharing of information among the respective agencies. While on occasion participating agencies need only aggregate information, usually agencies need to share personal information about a particular child and family. Laws protecting the confidentiality of such information collected about children and their families frequently create substantial obstacles to the information sharing process (Larson, 1993).

Clearly, confidentiality mandates are very important and they need to be upheld. They have been developed to protect basic rights to privacy which all service providers must closely guard and carefully respect. Also, it must be recognized that in addition to governmental legal requirements, most

professional disciplines have legal obligations or strong ethical standards that prohibit release of information about a client, patient, or student without consent (Greenberg, Levy, & Palaich, 1992).

As stated by Greenberg, Levy, and Palaich (1992), confidentiality requirements should not be looked upon as either an impenetrable barrier nor as something which can be casually disregarded. Based upon the experiences of practitioners who have dealt successfully with confidentiality requirements, as well their own analysis of this issue, these authors conclude that it is possible to develop means of exchanging information that are effective and practical on a wide scale, while still respecting legitimate rights to privacy (pp. 1-2).

Specific confidentiality issues should be addressed thoroughly by all involved in interagency collaboration planning. Among the most salient issues and concerns involving confidentiality which typically arise, and which require discussion -- and consensus -- are the following: (1) a clarification of why information sharing is critical; (2) a clear determination regarding who specifically should be involved in information sharing, specifically what information should be shared, and specific identification of any restrictions which might apply; and (3) specific procedures for obtaining "informed consent" and "common information release forms" (Davis, 1994d).

Service providers who are interested in developing effective collaboration with professionals from other agencies and disciplines often make a serious mistake at the very beginning of the collaboration process. They begin with a discussion of confidentiality requirements which are assumed to pose potential barriers to the overall process.

In this regard, Greenberg, Levy, and Palaich (1992) state, "Perhaps the clearest advice we heard from successful collaborators is that working on

confidentiality and information sharing should not be among the first tasks of a developing collaborative effort. Because the subject is complex and a mutually agreed upon approach for information is likely to entail compromises, it is important to have working relationships and commitment to joint efforts already firmly in place" (p. 7).

Confidentiality requirements typically represent a "hot button" issue. Some individuals will automatically rule out any potential benefits of interagency collaboration because they sincerely feel that their profession's code of ethics or licensing requirements would preclude the sharing of any of their clients' confidential information with other service providers outside of their profession. It usually takes a considerable amount of time to develop trust.

Therefore, while it is extremely important to clearly address all confidentially issues which may serve as potential obstacles to the collaboration process, it may behoove program planners to exercise patience and caution in this regard. Be reasonably sure that a sufficient level of trust among participants exists before attempting to deal with these issues.

Develop An Effective Evaluation Model.

Despite the many promises that most school-linked collaboration models, including full-service school models, appear to hold for meeting the needs of children and families at risk, the bottom-line question, quite appropriately, is Do these models really work? Do school-based health clinics, for example, reduce teenage pregnancy rates and curtail the spread of sexually transmitted diseases among youth? Opponents (e.g., Atwood, 1990; Schlafly, 1991; Simonds, 1993) frequently claim that these clinics not only fail to accomplish these

objectives but that their very existence promotes promiscuity, thus escalating problems among teenagers (Davis, 1995a, 1995b).

Are full-service schools, for example, which are open longer periods during the typical school day and, in some cases, on weekends, any more effective in increasing family involvement and reducing negative student behavioral patterns than are more traditional school models? What about the "brokering function" that full-service schools are supposed to serve by linking children and families with service providers? Is this really happening (Davis, 1995a, 1995b)?

The school-linked, service integration concept is still relatively new. Knapp (1995) indicates that much of the contemporary literature on school-linked services is heavy on advocacy and prescription but light on findings. Few empirical studies have been conducted which have yielded valid and reliable results relative to their overall efficacy. As Dryfoos (1994) pointed out, despite what appears to be compelling evidence that many of the comprehensive school-based programs already in operation are providing students and families with greater access to quality services, few of these programs have generated evaluation findings related to outcomes (Davis, 1994a).

Despite the difficulties in evaluating multicomponent programs such as the full-service school model, preliminary data collected and analyzed from several models designed to integrate health, education, mental health, and social service programs for youth at risk and their families indicate support for the full-service school concept. Positive outcomes have been documented in a variety of full service school-type programs (Davis, 1995a, 1995b; U.S. Department of Education & American Educational Research Association, 1995).

More robust research paradigms are necessary to accurately assess the efficacy of school-linked comprehensive service models. In their absence, major stakeholders in the school-linked, human services integration movement will be forced to rely on limited, anecdotal evaluation reports. These reports will not be sufficient to effect institutionalization of these models on a widespread basis because the "stakes are too high" in terms of both the fiscal and human resources involved. (Davis, 1995a, 1995b).

Demonstrate a Willingness To Trust and To Risk

Observers of interagency collaboration policies and practices seldom are at a loss when attempting to identify specific factors and conditions which are likely to undermine the efficacy of collaboration efforts. Most potential obstacles to effective collaboration are easily recognizable, and they have been well-documented. However, what often constitutes the most substantial obstacle to effective collaboration -- the real underlying obstacle -- usually is not one of the more commonly-cited factors or conditions such as the lack of a clear vision, the failure to acknowledge and to deal with professional turf and confidentiality issues, or the lack of an effective evaluation model. Rather, the most paramount and often the most difficult obstacle to overcome is the inability and/or the unwillingness on the part of participants to demonstrate the necessary level of trust and respect which is required to carry out the process successfully.

Clearly, trust and respect must be earned, and, at times, this involves time. Individuals generally develop trust in and respect for others only after they have had consistent opportunities for mutual interaction. However, program planners must be able to maintain a basic sense of trust in and respect for others in the process. They do not necessarily have to agree on

every single point or issue involving what would be the most effective approaches to help children and families. In fact, effective collaboration can occur even when strong disagreements on some issues may exit among participants within this process -- as long as everyone is willing to acknowledge these differences and to demonstrate a sufficient level of trust in them as individuals as well as for the integrity of the collaborative process as a whole.

Effective collaboration requires that participants not be concerned with "who gets the credit" for the positive outcomes which hopefully occur for children and families as a consequence of their collaboration efforts but rather that they demonstrate a sincere commitment to ensure that the process works, resulting in positive outcomes for everyone's clients. Participants must demonstrate a strong willingness to risk themselves in the process.

Concluding Perspective

School psychologists currently are being presented with a unique opportunity to help shape the future of programming services for children and families throughout our nation's public schools. This opportunity has arisen due to the emergence during the 1990s of several health, educational, human services, and community reform movements which are designed to develop and implement more comprehensive, integrated, and effective programs to meet the multiple, complex needs of large and growing numbers of American children and families considered to be at risk. Prominent among these movements are those which involve the development of comprehensive school-linked and school-based collaborative programs which are designed to more effectively provide a broad spectrum of mental health services for students and their families, ranging from prevention to intensive treatment.

Traditionally school psychologists have devoted the majority of their time in public schools directly working with special education students and special education staff in the areas of pupil assessment, programming, and attending related meetings. Their involvement with the school district's broader population of students generally has been very limited. However, given the uncertainties which currently exist involving the future "face of special education" as a result of proposed changes being considered as part of the reauthorization of IDEA (e.g., the widespread support which appears to exist for census-based funding) the traditional roles and responsibilities of school psychologists, irrespective of any of the human services reform movements which are taking place, may be in the process of being dramatically altered.

It is suggested that school psychologists can play a critically important role not only in improving the overall human services delivery system for children and families at risk but also they will have, because of the reasons cited above, increasing opportunities to improve the emotional and behavioral well-being for all children, youth, and their families within their jurisdiction. For this to occur, however, key school personnel must demonstrate a commitment and a willingness to provide school psychologists with a great deal more flexibility relative to the assigned roles and responsibilities which they now have within most school environments.

To continue to restrict the responsibilities of school psychologists largely to individual student assessments and student programming consultation within the special education domain is suggested as being short-sighted, thereby preventing school psychologists from assuming a broader mental health services coordination role involving all students and families within schools. In particular, school psychologists should be encouraged to

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broaden their responsibilities within schools to focus their efforts substantially more on prevention-type activities with students, families, and staff. Also, the establishment of family resource centers within schools and communities have been shown to be very effective as vehicles for producing positive outcomes for children and families. School psychologists frequently can offer valuable coordination, consultation, and training services within these centers.

It is suggested that school psychologists themselves, however, must also be willing to make a commitment to develop more effective collaborative programming services for students and their families. This commitment might best be demonstrated by their making an effort to increase their current level of awareness regarding contemporary school-linked and school-based collaboration programs, especially those collaborative efforts currently in operation which focus primarily on mental health needs of students and their families. Two excellent resources in this regard are the national centers which have been established to address issues involving the mental health needs of students in our schools: (1) The School Mental Health Project/Center for Mental Health in Schools, Department of Psychology, UCLA (Howard Adelman and Linda Taylor, Co-Directors), and (2) The Center for School Mental Health Assistance, Department of Psychiatry, University of Maryland at Baltimore (Mark Weist, Director).

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